(2) Pass-through costs [subpart 4, item A, subitem (7)]			
(3) Base year admissions [subpart 3, item M]			
(4) Pass-through cost per admission [subitem (2) divided by subitem (3)]			
(5) Base year patient days [subpart 3, item O]			
(6) Pass-through cost per day of inpatient hospital services [subitem (2) divided by subitem (5)]			

C. The department shall determine the rate per admission for a budget year as follows:

Rate Per Admission = [(Adjusted base year cost for each admission) multiplied by (budget year HCI), plus (budget year pass-through cost per admission)]

D. The department shall determine the rate per day for a budget year as follows:

Rate Per Day = [(Adjusted base year cost per day of inpatient hospital services) multiplied by (budget year HCI), plus (budget year pass-through cost per day of inpatient hospital services)]

E. After the end of each budget year, the commissioner shall redetermine the rate per admission or rate per day, or both. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted costs in item B, subitem (2) for that year. If an adjustment indicates an overpayment to the hospital, the hospital shall pay the commissioner the overpayment within 60 days of written notification from the commissioner. If the adjustment indicates an underpayment to the hospital, the department shall pay that hospital the underpayment within 60 days of written notification from the commissioner. Interest charges will be assessed according to part 9500.1125, subpart 5.

F. A hospital with minimal participation shall be reimbursed on a rate per day in lieu of a rate per admission unless the hospital elects to be reimbursed on a rate per admission basis. To obtain reimbursement on a rate per admission basis, the hospital shall submit a written request to the commissioner at least 30 days prior to the beginning of the budget year for which reimbursement is sought.

G. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, subpart 1, substituting the term adjusted base year cost per admission with the term rate per admission or rate per day.

H. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

I. Appeals must be made according to parts 9500.1140 and 9500.1145.

Subp. 5. Determination of reimbursements for medicare crossover claims. The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

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9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. Purpose. Under Minnesota Statutes 1982, section 256.966, the annual increase in the cost per service unit paid to any vendor under medical assistance or general assistance medical care shall not exceed eight percent for services provided from January 1, 1982, until part 9500.1150 becomes applicable.

Subp. 2. Definitions. As used in this part, the following terms have the meanings given them:

A. "Adjusted base year costs" means allowable base year costs cumulatively multiplied by the eight percent cap for a hospital's fiscal years prior to the rate year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Allowable rate period costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's rate period medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs.

D. "Eight percent cap" means the limit on the annual cost increase per service unit under Minnesota Statutes, section 256.966.

E. "Rate per admission" means the allowable base year cost for each admission multiplied by the eight percent cap and adding the rate year pass-through cost per admission.

F. "Rate per day" means the allowable base year cost per day of inpatient hospital services multiplied by the eight percent cap and adding the rate year pass-through cost per day of inpatient hospital services.

G. "Rate period" means any portion of a hospital's fiscal year that includes any portion of the period from January 1, 1982, until part 9500.1150 becomes applicable.

H. "Total hospital costs" means the costs identified in the hospital's base year medicare/medical assistance cost report, HCFA Form 2552, 1981 revision, Worksheet A, column 3, line 84.

Subp. 3. Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day. The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to Q:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. net reimbursable inpatient hospital costs (subtract item B from item A);

D. total hospital costs (Worksheet A, column 3, line 84);

E. malpractice insurance costs (Worksheet A, column 5, line 71);

F. net total hospital costs (subtract item E from item D);

G. ratio of net reimbursable inpatient hospital costs to net total hospital costs (item C divided by item F);

H. pass-through costs, except malpractice insurance costs;

I. medical assistance pass-through costs, except malpractice insurance costs (item G multiplied by item H);

J. routine service costs before limitation (Worksheet D-1, line 57);

K. reimbursable routine service costs (Worksheet D-1, line 61);

L. reimbursable routine service costs subject to limitation (subtract item K from item J);

M. allowable base year costs (subtract item I from item C and add item L);

N. base year admissions excluding medicare crossovers;

O. allowable base year cost for each admission (item M divided by item N);

P. base year patient days excluding medicare crossovers; and

Q. allowable base year cost per day of inpatient hospital services (item M divided by item P).

Subp. 4. Determination of allowable rate period costs, allowable rate period cost for each admission, and allowable rate period cost per day. The department shall determine allowable rate period costs from the rate period medicare/medical assistance cost report using data from the HCFA Form 2552 worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to N:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5);

C. net reimbursable inpatient hospital costs (subtract item B from item A);

D. total hospital costs (Worksheet A, column 3, line 84);

E. malpractice insurance costs (Worksheet A, column 5, line 71);

F. net total hospital costs (subtract item E from item D);

G. ratio of net reimbursable inpatient hospital costs to net total hospital costs (item C divided by item F);

H. pass-through costs, except malpractice insurance costs;

I. medical assistance pass-through costs except malpractice insurance costs (item G multiplied by item H);

J. allowable rate period costs (subtract item I from item C);

K. rate period admissions excluding medicare crossovers;

L. allowable rate period cost for each admission (item J divided by item K);

M. rate period patient days excluding medicare crossovers; and

N. allowable rate period cost per day of inpatient hospital services (item J divided by item M).

Subp. 5. Determination of rate per admission and rate per day. The following data shall be determined:

A. The department shall determine the rate period pass-through costs per admission or per day of inpatient hospital services, or both, for the rate period as specified in part 9500.1150, subpart 4, item B.

B. The department shall multiply the allowable base year costs by the eight percent cap.

C. The department shall determine the rate per admission for a rate period as follows:

Rate Per Admission	=	Lesser of the [(allowable base year cost for each admission) multiplied by (eight percent cap), or the allowable rate period cost for each admission plus (rate period pass-through cost per admission)]

After the initial year, adjusted base year costs are used in the rate per admission formula instead of allowable base year costs.

D. The department shall determine the rate per day for a rate period as follows:

Rate Per Day	=	Lesser of the [(allowable base year cost per day of inpatient hospital services) multiplied by (eight percent cap), or the allowable rate period cost per day of inpatient hospital services plus (rate period pass-through cost per day of inpatient hospital services)]

After the initial year, adjusted base year costs are used in the rate per day formula instead of allowable base year costs.

E. A hospital with minimal participation, as specified in part 9500.1150, subpart 4, item F, shall be reimbursed on a rate per day in lieu of rate per admission unless the hospital elects to be reimbursed on a rate per admission basis.

F. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, substituting the term adjusted base year cost per admission with the term rate per admission or rate per day.

G. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

H. Appeals must be made according to parts 9500.1140 and 9500.1145.

Subp. 5a. Determination of reimbursements for medicare crossover claims. The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. Four percent reduction. Reimbursement for admissions is reduced four percent from January 1, 1983, through June 30, 1983, as provided in Laws of Minnesota 1982, Third Special Session, chapter 1, article 2, section 2, subdivision 4, paragraph (a), clause (4). Each rate per admission and each rate per day as determined under subpart 4 for each admission during the period from January 1, 1983, through June 30, 1983,

shall be reduced by four percent.

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